Chapter for The Oxford Handbook of Phenomenology and Psychopathology

Title: Psychopathology and Law

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Introduction

Mind is central to law and law shares the problem of mind's anomalies with psychiatry. But psychiatry and law approach psychopathology with very different systems of knowledge.

Psychiatry, as a branch of medicine, comes at psychopathology with categories of symptoms, diagnoses, biological dysfunction and treatment. But it also makes use of psychological and sociological concepts. Psychology assumes a continuity of psychopathology with normal mental functioning and sociology assumes social determinants of psychopathology. This plural, or "biopsychosocial", body moves along. Its organs are professional organisations, service delivery, training programmes, research activity, and exercises in self-critique (1, 2). It creates the shared professional language of clinical psychopathology.

Law is concerned with justice and aims to respect the self-determination of adults whom it considers are in sound mind.[1] A core concept for human rights based law is personal autonomy and law operationalizes this with the components of valid consent (3). In recent decades, these categories have increasingly regulated, or have attempted to regulate, areas of health and social care where the language of clinical psychopathology is indigenous (4).

[1] See for example Justice Benjamin Cardozo's classic statement of this principle in *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914). "Every human being of adult years and sound mind has a right to determine what shall be done with his own body". In various forms it has been repeated in superior courts since.

In the UK, and in several other jurisdictions, the psychiatric and legal approaches to psychopathology are increasingly mixing (5) and this trend will probably continue (6). Given the different origins and professional perspectives of clinical psychopathology and law this mixing is liable to create confusion but it also affords opportunities. Several commentators have criticised the current state of clinical psychopathology as narrowly based on symptoms (7-11) and criticisms of mainstream theories of personal autonomy are also being expressed (12-14). These critiques emphasise the relational, social and value-laden aspects of autonomy and complain that mainstream accounts are narrowly individualistic or formal.

When overlapping areas have become narrowed, or siloed, interdisciplinary research becomes important. Progress in both clinical psychopathology and legal understandings of personal autonomy may come from research strategies that include psychiatric, philosophical and legal perspectives on psychopathology (9).

Phenomenology

What about phenomenology? In psychiatry the word phenomenology strongly connotes Karl Jaspers' approach to psychopathology with his majestic textbook 'General Psychopathology' as the primary source (15). Ghaemi (16) has persuasively argued that the core, and lasting, feature of Jaspers' approach was methodological pluralism - the introduction of the distinction between the methods of understanding (*Verstehen*) and explanation (*Erklären*) to psychiatry's self-consciousness. But phenomenology also has a specific meaning in philosophy (17). I understand phenomenology in this philosophical sense as a qualitative discipline that interprets structures of subjectivity or the meanings and values structuring intentional mental life. It is both descriptive and analytical and engages with ethical and ontological matters. This philosophical sense of phenomenology has significant links with psychiatry (18) but much of it lies outside of Jaspers' approach.

On psychopathology and law Jaspers was remarkably silent. Before the 1930s he seems (by his own admission) to have taken the Imperial certainties of German mental health law rather too much for granted (15) (pp793-95;839-40) and, from the 1940s on, he seems to imply that little could be said about the relation of personal autonomy to psychopathology at all (15) (pp755-6). That is perhaps understandable given his historical and cultural context. But the 21st century context is different and, as we shall see, we need to find balanced ways of thinking about psychopathology from an ethical and legal point of view.

Plan for this chapter

Both Jaspers' methodological pluralism and an approach to psychopathology drawing upon phenomenology as a philosophical, qualitative discipline are used to inform the interdisciplinary approach taken in this chapter. It will start with a short introduction to the legal components of valid consent and then focus on decision-making capacity (DMC) and the clinical categories of frontal brain injury, schizophrenia and depression. It will look at DMC using clinical epidemiological methods (in Jaspers' mode of *explanation*) and then clinical phenomenological methods (Jaspers' mode of *understanding* – though supplemented by phenomenology in the philosophical sense).

Valid consent

Imagine you are deciding about a treatment, selecting a home or purchasing a car. Now ask yourself, what makes these decisions valid?

This question concerns law because the decisions involve different parties in society (you, your doctor, your family, your bank, etc.) and law needs to work out whom to justifiably hold accountable should disputes arise. Law's approach is to posit 3 elements of valid consent (or valid decision): relevant information, DMC and voluntariness (3).

Relevant information
This element recognises that a person cannot be held accountable for a decision unless they are in possession of, or could be in possession of, relevant and reasonable amounts of information about the nature and consequences of the decision. I might decide to take medication A but if I don't know that medication A is for psychosis or that it may have side effects then law will question valid consent.

Decision-making capacity (DMC)
DMC is the presumption that the psychological abilities upon which decision-making depends are present. The sort of decision-making abilities that are relevant here are ones that relate to self-determination, or, in other words, abilities to make decisions for oneself. Legislators and courts have the final word on what these abilities are. Grisso and Appelbaum have distilled much US case law on DMC into a four abilities model (19).

1. Ability to understand relevant information
2. Ability to appreciate that information
3. Abilitiy to reason with that information
4. Ability to express a choice

In English law "appreciation" and "reasoning" are replaced by "use" and "weigh" (20). Whatever the exact words used, the law is trying to capture abilities to absorb relevant information, deliberate with that information and effect choice.

The abilities must relate to specific decisions when a decision has to be made (or was made), e.g. a treatment decision, a residence decision, a financial decision. This is the so-called functional test of DMC. It is not a diagnostic test or a test of "reasonable" decision. One can have DMC in the presence of symptoms of mental illness and one can have it if making a choice that many would regard as unwise or unreasonable. To lack DMC it must be shown that inability to decide is inability due to psychopathology[2]. If any of these abilities are absent then DMC is lacking and valid consent (or refusal) cannot be given.

Recent legal debate is addressing a grey area in between valid consent and lacking DMC called 'supported decision-making'. The idea is that if an individual with mental disability is at risk of lack of DMC then the provision of support may remove that risk and enable valid consent to be achieved. (13). Debate focuses on what this support should look like and its scope and limits.

Voluntariness
Voluntariness is the requirement that choices are not valid if they are coerced. In the extreme case a gun to the head with the threat to pull the trigger unless X is decided

[2] There is some debate about whether this "due to" requirement is superfluous but, if it is superfluous, it will be superfluous because the absence of the psychological abilities is a mental inability itself (i.e. an mental anomaly). So, either way, psychopathology and lacking DMC have a deep connection.

rather than Y is not a valid consent to X even if all relevant information is disclosed to the person deciding and all decision-making abilities (above) are present. In practice coercion comes in shades and the law gives recognition of a continuum of threat to voluntariness with the concept of 'undue influence'.

With this brief legal outline of valid consent in place we can see that the component where psychopathology most clearly becomes relevant is DMC. But we can also see that *clinical* psychopathology and DMC are not the same thing. To look at psychopathology through the perspective of DMC is to look at it differently.

Explaining **DMC in terms of clinical psychopathology**

One way to *explain* (in Jaspers' sense) DMC in terms of clinical psychopathology is through the use of operationalized measures and the statistical methods of epidemiology. Random sampling from clinical settings using ICD-10 codes, symptom scales and a validated tool for the assessment of DMC (the "MacCAT-T" (19)) allows measurements of both clinical psychopathology and DMC and for associations between these variables to be tested statistically.

Here I will summarise a selection of studies from the literature that illustrate this approach at work and which contribute to knowledge in psychopathology and law.

Psychiatric vs medical

Much debate has concerned whether there is an essential difference between psychiatric disorders and medical disorders (21, 22) but how does this debate relate to DMC? When acute psychiatric settings were compared with acute medical settings on prevalence of DMC for treatment there were in fact no significant differences (23). If one performs a sub analysis of the relevant decision-making abilities, then inability to appreciate was more salient than reasoning in the psychiatric setting and vice versa in the medical setting (4).

So a remarkable parity exists between psychiatry and the rest of medicine in terms of DMC; but the underlying decision–making inabilities in the two settings are different. Appreciation is a more evaluative ability than reasoning and because the fact/value dichotomy and relativistic attitudes toward values are so influential in contemporary culture (24) it is likely that the objectivity of DMC assessment will attract more skepticism in psychiatric contexts than medical contexts. But reasoning is also an area of considerable debate in psychology and philosophy because of plentiful evidence of poor reasoning in the healthy population (25) and so skepticism can be directed to the medical setting also (26). This parity of skepticism simply points to the need for more in depth study of what appreciation and reasoning, or "use or weigh" abilities mean.

Frontal brain injury

In a sizable number of cases of damage to the human frontal lobe neuropsychology has been unable to measure impairment (27) despite patients having marked problems with behavior and self-awareness that can be described. The famous case of Phineas Gage (28) is a prototype here and in many similar cases DMC is at issue. In a study of patients with frontal brain injury using detailed neurocognitive tests and a legal standard for the appreciation ability, Dreer and colleagues (29) reported that the problems meeting the appreciation standard were unexplained by extant neurocognitive measures. This clarifies an interesting conceptual problem: what kind of evidence is of use in assessments of DMC in frontal brain injury? In depth clinical phenomenological studies may help us arrive at an answer.

Schizophrenia

The symptom profile of schizophrenia is varied and complex and the validity of the diagnostic category remains disputed (30). Which symptoms associate most strongly with DMC for treatment in people with schizophrenia? A study of inpatients with psychotic symptoms found that there is a rank order in the strength of association. Delusions and thought disorder associated most strongly and hallucinations and cognitive impairment associated least strongly (31). Also, the category of schizophrenia was associated with regaining DMC more slowly compared with other diagnoses (32).

So, looked at through the perspective of DMC for treatment, the symptoms of schizophrenia that are of greatest interest are delusions and thought disorder rather than hallucinations and cognitive impairments. And if one wants to know about time frames for regaining DMC, then the diagnosis of schizophrenia is not without predictive validity. Many questions remain however about what is underpinning these associations between schizophrenia and DMC.

Depression
Depressive is extremely common and can be severe, recurrent and disabling. The psychiatric literature on depression is vast and there is good evidence for effective treatments. But how does depression impact upon DMC for treatment? Systematic review of empirical evidence reveals a tiny literature in this area and DMC tools have measurement problems (33). This may not be a practical problem if psychiatrists have other reliable ways of identifying DMC. One possibility is the clinical concept of insight. If a patient with severe depression is unable to decide for themselves about treatment then, so the thought may go, they will lack insight and be flagged up for professional attention that way. But studies of depression and insight show that insight lacks sensitivity for severe depression (34) and also lacks sensitivity as a test of DMC (31). In other words, patients with severe depression do not have characteristically low scores on insight and if they score high on insight this can be consistent with lacking DMC.

So we have another conceptual gap and a new question: what are the relevant variables for losing the ability to decide for oneself in depression? Again, in depth clinical phenomenological studies may help.

Understanding **mental capacity in terms of clinical phenomenology**

We have seen that *explaining* DMC in terms of clinical psychopathology yields a kind of knowledge. It gives a pragmatic mapping and identifies gaps where more basic conceptual work is required. Where gaps are found the methods of *understanding* become indicated to illuminate the meaningful relations between states of mind and abilities to self-determine. Here sampling is purposeful rather than random and interpretation is in-depth rather than statistical. A method of second-person phenomenology has been adapted for this purpose (35). In brief, this method uses first person reports but probes and interprets them in the context of an open structured interview in which the interviewer (and researchers) aim to make sense of the reports and what they imply for self-determination. I will now report on some studies which, using this method, address some of the gaps identified above.

Frontal brain Injury
The gap between neurocognitive tests of human frontal brain function and inability to use and weigh information, discussed above, requires a bridge to be constructed. A recent study reviewed relevant neuropsychological research on awareness of deficit, metacognition and somatic markers and conducted in-depth interviews with people with frontal brain injury (36). A key finding concerned *online awareness of disability*.

Consider this excerpt from an interview with a research participant with injury to the frontal lobe:

> ABI4: It was really weird because in the hospital, everyone else was really bad. Like they couldn't walk or talk, totally mute … . But I was fine, I was walking and talking, and I thought everything was fine. And when I went home, I was like gone. I couldn't walk, couldn't walk upstairs. I was stuck in bed, and I couldn't talk … . But when I was walking and talking I was fine. Every single day in the hospital I was asking if I could go home. "I want to go home, I want to go home. I'm fine, look at me. You can see I'm fine." So eventually they gave in and said "Go on then, go home". And once I was home it was just different, you know. Before that I'd felt like I was better, I was fine … .
> Interviewer: So when you were in hospital you felt it was all ok, you were walking around, you could speak, think, express yourself … ?
> ABI4: I was feeling fine, … but once I got out of hospital I realized how bad I was.
> Interviewer: Outside of hospital it didn't work out?
> ABI4: No, that's when I realized how bad I was.

The excerpt shows that ABI4 does have awareness of his disability ("I realised how bad I was."). In the interview, and retrospectively, ABI4 shows awareness of his disability. But the excerpt also attests to an episode in which ABI4 lacked that awareness in a context when a decision had to be made.

A few minutes later in the interview:

> ABI4: I want to get out, have a fresh start where no one knows me, and I don't know anybody, and start all over again. Start totally fresh, start a totally fresh life, a totally fresh life.
> Interviewer: And when you think like that, do you want to do it by yourself, alone, or do you want help from others?
> ABI4: Do it myself.
> Interviewer: Do it yourself?
> ABI4: Yeah. I mean my uncle, when he got out of the nick … 9 years or 10 years … . He's out now, he's living up north ... . When I get out of hospital I could go and see him … .
> Interviewer: So what you're saying is that what you prefer is to start again, without any help from others. That's very, very different to hospital, isn't it, where there's an enormous amount of help that you're getting.
> ABI4: I don't need this bollocks [hospital care], I'm sick of it.

Recall that ABI4 has just been articulating his awareness of his disability and significant support needs. But as the conversation began to involve deliberation that implicates future support needs, he was unable to bring that awareness "online" to inform his decision-making. The consequences of such an inability can be seen in an excerpt from a different participant, in which the difference between offline and online awareness was exhibited rather dramatically.

> Interviewer: I mean, for example, in the restaurant you had somebody kind of shout at you after you got irritated and you kind of got into an argument which had got a bit out of hand, and it sort of started because, whereas before you would have managed the situation, now you lose your temper?
> ABI3: Yeah.
> Interviewer: Can you think of examples like that?

> ABI3: Yeah it does happen. It does happen. [*Noise from another patient in background*.] I'll go out there and punch her on the f***ing nose in a minute if she don't shut up!

Awareness of disability is an important variable for DMC in the population of patients with frontal brain injury. However, awareness of disability can take different forms (retrospective, concurrent, online) and psychiatry and law need to be able to recognize all of them. Practical consequences for assessment of DMC in frontal brain injury flow from this result (37, 38).

Schizophrenia

Jaspers thought that phenomenology was important in identifying schizophrenia as a valid category. In other words, he thought that when psychiatry takes an entirely 3rd personal approach to schizophrenia (e.g. an entirely biological approach) it was at risk of losing its object. But he thought phenomenology was important in a sort of negative sense. His view seemed to be that in trying to interpret certain core patient experiences we can experience a limit in the scope of *Verstehen* as a method of interpretation (this is what he meant by "un-understandability"). This limit, together with characteristic patient self-descriptions such as "passivity" experiences, denoted schizophrenic psychic life and demarcated it from affective psychic life (15) (pp 577-582). So the core phenomenology of schizophrenia for Jaspers seemed to be a conjunction of distinctive first-personal experiences (e.g. passivity symptoms) and a distinctive second-personal experience (the interviewer experiencing a fundamental limit in the interpretability of those experiences).

Assessment of DMC involves interpretation (typically centered on a face-to-face interview) so what might this Jasperian point mean in relation to DMC assessment?

To illustrate the challenges of interpretation being referred to here, take this speech act from a patient with a diagnosis of schizophrenia.

> I went to Samoa. This has been my life in total. I never went there. I was taken there again. We got on the plane that took off, we were supposed to be flying local, we thought, like in France or something. The plane ended up in Tahiti, but the islands were called something in Samoa, so I can't remember whether it was Tahiti or Samoa we were in. I think we were in Samoa, but my family, someone was saying it was Tahiti. We landed on an Island. In those times they never had airstrips. The plane that brought us down was a cargo plane because they never had passenger planes. My brother got hold of me and there was a great white shark in the water, off a fair bit – it looked like somebody was carrying a door on their back – it was that big the shark, its fin. (39)

Clearly, understanding what is being meant in this communication is going to strain our common sense or folk psychological resources.

In the context of assessment of DMC, Banner and Szmukler (40) have proposed interpretative approaches drawing upon the 'radical interpretation' of philosopher Donald Davidson. The suggestion is that in DMC assessment we should aim to clarify the meaning of a decision-making process using the principle of charity. Davidson developed the principle of charity as way to interpret any alien speaker from scratch (think of an anthropologist's task of interpreting the language of a tribe where no assumptions can be made about shared beliefs or words). According to Banner and Szmukler when, after good faith attempts, radical interpretation does not

yield translation of meaning about a decision-making process – or a person's will - then one may be unable to attribute DMC. They draw a parallel with Jaspers' concept of un-understandability.

Another interpretative approach is to try to understand the phenomenological structure of the decision-making abilities and inabilities at play in schizophrenia. On this approach lacking DMC in schizophrenia is not inherently to do with un-understandability but to do with threats to self-determination. When overt delusion and thought disorder is stripped back with close textual interpretation of dialogue what kind of underpinning cognitive and emotional rigidity can be identified? How does this rigidity threaten the ability to use or weigh information? This is work in progress.

Depression

Psychopathologists have often remarked on the understandable nature of depression. It is, for example, easy to empathise with feeling bad or hopeless in the wake of the negative life events that often accompany a depressive episode. But in relation to DMC for treatment this can be a catch. Appelbaum and Roth have put it well in the context of challenges in general medicine (41):

> "Of all the psychopathological processes associated with refusal [of medical treatment], depression is the most difficult to recognize, because it masquerades as, 'Just the way I would think if it happened to me' … The depressed patient is frequently able to offer 'rational' explanations for the choices that are made."

We have seen above that there is work to do to specify decision-making abilities in depression. A key finding from a recent study aiming to do this (35) concerns *temporal abilities*.

This excerpt illustrates what requires interpretation:

Interviewer:	What's in your mind?
D4:	Well nothing
Interviewer:	And in your feelings?
D4:	No, I ain't got no feelings…
Interviewer:	Do you feel sad?
D4:	No I don't feel sad, I got no feelings at all, I don't think. I'm anxious again. You know… everything's a distraction… to take me away from what's going to happen. You know I go back to my room and lie there ready, that's why I lie in my room.
Interviewer:	Ready for what?
D4:	Ready for death.

In this case of someone with severe depression in good physical health, the future was being experienced in a characteristic way. The ability to experience the future as open was compromised (death was the dominating awareness) and there was inability to experience a present task of deliberation and choice about treatment as shaping the future. There was inability to project oneself into significant normative differences and also inability to imagine different future treatment scenarios in some degree of detail when needed. Taken together this cluster of temporal inabilities can call into question self determination in relation to treatment. How can there be using or weighing about X when the future has become normatively flattened in relation to X?

In the cases of mild-moderate depression studied, these temporal abilities were preserved (35) and here the concept of supporting decision-making to enable valid consent (see above) is likely to be more relevant than DMC assessment.

With an understanding of the relevant abilities and inabilities, we are in a better position to try to implement better strategies for the assessment of DMC in depression.

Conclusion

Psychiatry and the Law share psychopathology as a problem. Once we step back and reflect that psychopathology concerns the human being then the shared nature of the problem is not surprising. Clinicians are concerned with promoting human health and quality of life; law is concerned with ensuring that the human being's fundamental rights are respected. One point of specific overlap concerns DMC.

This chapter has summarized an interdisciplinary research approach to DMC. Some classic concepts from the clinical psychopathological stable – brain injury, schizophrenia, delusion, insight, and depression – have been looked at through the perspective of DMC and using the methodological pluralism of Jaspers. Through the perspective (or lens) of "*Erklären*" measurement of DMC patterns in selected clinical populations has been presented and this has also clarified some questions that are unsolved such as 'how does frontal brain injury or depression impact on abilities to self-determine?" These questions have then been addressed from the perspective of 'Verstehen' and this has generated new hypotheses about decision-making abilities (i.e. opportunities for the perspective of *Erklären* to grow) but also new illuminations of self-determination to aid those who must assess DMC in individuals. Ultimately, the assessment and navigation of DMC relates to a single human being and, as Jaspers taught us, a human being will elude the single perspective of either *Erklären* or Verstehen.

Much work is still to be done in this area of psychopathology and law and the field of research is comparatively new. But there are grounds to think the interdisciplinary approach outlined here contributes to a balanced and objective understanding of the normative dimensions of psychopathology.

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